of bile; one may readily understand that the accumulation of this material might be of importance. Researches in other departments of medicine go to show that in various diseased conditions, the lipoid content of the blood is greatly changed. It is thought by many that lipoids in the blood are a distinct element in producing epileptic convulsions, and that convulsions occur when the plasma of the blood reaches a certain stage of concentration. If the lipoids thus contained produce convulsions, but act by poisoning the cells of various organs, the decomposition of these cells would readily account for the formation of lipoids. This substance is probably not cholesterin but probably another lipoid. In the placenta lipoids are found more abundantly in the first six months than in the last three. In the blood the relationship is reversed. In cases of abortion produced by the toxemia of pregnancy an increase in fatty substances is often observed, which is not peculiar to pregnancy, but is often seen in the infectious diseases with or without fever. It is evident that the changes which precede eclampsia and toxemia are gradually developed and are not of sudden origin.

The Formation of Bone in the Skeleton of the Mother during Pregnancy.—DREYFUSS (*Arch. f. Gynäk.*, 1921, cv, 126) has made extensive investigations regarding the question of the formation of osteophytes during pregnancy. He finds that by using the stereoscope with roentgen-rays one can demonstrate the changes in the wall of the skull in pregnancy very plainly. He finds that instead of an increase of 50 per cent—as has been already computed, largely from the examinations of the skeleton of the cadaver—in the living an increase of 33⅓ per cent is what is really present.

A Case of Necrosis of the Intestine in the Ninth Month of Pregnancy.—PILSKY (*Zentralbl. f. Gynäk.*, November, 1921, p. 1662) reports the case of a primipara, who up to two days before admission to the hospital, seemed to be in good general health. She was then taken with sudden pain in the region of the stomach, with vomiting. On the following day the pain grew better, but the prostration and vomiting continued. A midwife administered castor oil without improving the patient's condition. Since the beginning of her illness the patient had no bowel movement and passed no gas through the intestine. Severe abdominal pain again returned and labor pains developed which brought the patient to the hospital. On examination she was badly nourished, without edema or eruption; the tongue was moist and not coated. The abdomen was somewhat enlarged and there was diffuse tenderness over the whole abdomen; the pelvis was normal. The head of the child was in the pelvis; the heart sounds rather feebly heard. Labor went on and a poorly developed child (42 cm. long) was spontaneously born. The patient felt considerably better after labor, although she vomited freely of greenish fluid. This continued until the material vomited became blackish green and the abdomen was somewhat tender. The tongue did not look badly. The patient gave no sign of peritonitis. During the night the distention of the abdomen and tenderness increased and a high enema gave no result. The lower abdomen was very tender, especially in the region of the

large intestine, and a diagnosis was made of intussusception. At operation dark reddish fluid was found in the abdomen. The peritoneum was not clear and the condition of the intestine and omentum was abnormal. From the posterior wall of the uterus there were bands of adhesions of a grayish yellow color which bound down the intestine. On examination a considerable portion of the intestine was found necrotic, and it was necessary to resect a piece (35 cm. in length). The abdominal cavity was irrigated with warm salt solution and gauze drainage was inserted. The patient died some hours afterward, as the operation had been undertaken too late. It is probable that the pregnancy was at least the indirect cause of the abdominal condition. The growing uterus had forced the intestine up and occluded a portion of it and brought about the necrosis. The painful movements of the intestine had brought on the labor, and the labor had increased the difficulty by aggravating the inflammation of the bowel. Postpuerperal ileus develops because the intestine in pregnancy loses its tone and because in some cases labor is difficult and greatly prolonged. This is seen in contracted pelvis, hydramnios and in cases of pregnancy complicated by diseases of the heart or kidneys. Evidently if operation is to be done in these cases, it must be instituted very promptly.

Fibroids Complicating Pregnancy and Labor.—MARSHALL (*Lancet*, December 10, 1921) states that in pregnancy complicated by fibroids the production of abortion is not indicated. The development and comparative safety of delivery by abdominal section makes this unnecessary. Many women having fibroids do not conceive, and in some cases women who had born children, subsequently became sterile because fibroids developed. With fibroids, submucous or polypoid, there was a tendency to abortion, but in even these cases the pregnancy might go on to term. All varieties of fibroids may bring on abortion. He describes the case of a woman in her second pregnancy who had a large subserous fibroid projecting from the anterior uterine wall at the level of the umbilicus. There was slight hemorrhage and labor gradually came on, the child being delivered without difficulty. At each uterine contraction the fibroid became hard and protruded and this gave the patient severe pain. Pregnancy complicated by fibroids may be divided into those cases which might safely go to term. those in which myomectomy can be done and those which require hysterectomy. Abortion should not be performed. Large tumors sometimes will rise out of the pelvis as the uterus grows and thus give room for the normal birth of the child. In those cases where the patient might go to term the main complications which are to be feared are pain and hemorrhage. These patients should first be treated by rest, sedatives and general treatment. Where a subserous fibroid became twisted and necrosis developed the indications for operation were clear. This was also true in prolapse and impaction of a subserous fibroid in the pelvis or a fibroid on the anterior uterine wall causing retroflexion likely to end in abortion, great pain or incarceration. The subserous type of tumor was best adapted for operation. Where pregnancy was complicated by an interstitial fibroid of any size it was best not to attempt its removal because of the hemorrhage,